STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on staff interviews, record review, review of facility documentation and facility policy for 1 of 2 sampled residents (Resident #13) reviewed for mistreatment, the facility failed to ensure Resident #13 was not treated in a scolding manner. The findings include: Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 2 persons with transfers and toileting. The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings. On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you? On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the Investigation Summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her. The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me? (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 4/4/24 at 3:00 PM identified that after her review of the incident, NA #3 approached Resident #13 to confront him/her about stating that NA #3 was not providing him/her care. The DNS further identified that the incident could be classified as abuse due to willful action and confrontation by NA #3. Additionally, the DNS identified that the Administrator was a witness to the incident and that the Administrator intervened with getting assistance from another staff person for Resident #13 on the day it occurred. Interview with NA #2 on 4/9/24 at 11:30 AM identified that on the afternoon of 2/22/24 she observed NA #3 in the dining room with Resident #13. NA #2 further identified that she observed NA #3 turn Resident #13's wheelchair, pointed her finger in Resident #13's face and yelled You should have waited, I told you to wait. Upon leaving the dining room, NA #2 indicated that she immediately reported the incident to the Administrator. Interview with NA #3 on 4/9/24 at 11:45 AM identified that Resident #13 had a habit of telling people that she does not take him/her to the bathroom and that on 2/22/24 she asked Resident #13 why he/she was telling people she would not toilet him/her. She further identified that Resident #13 started yelling at her and that she did not recall shaking her hand at Resident #13. Interview and record review with the DNS on 4/9/24 at 12:15 PM indicated that NA #3 was given a written disciplinary action by the Administrator on 2/27/24. The DNS provided the documentation on the Facility's Investigation Summary Form/The Conclusion (undated) which identified that the facts in the investigation supported the allegation of verbal harassment by NA #3. Review of the facility policy, [NAME] of Rights/Residents (undated), directed that residents shall be treated according to the guidelines in the Resident's [NAME] of Rights at all times. Review of the Resident's [NAME] of Rights (undated) identified that residents have the right to be treated with consideration, respect and full recognition of their dignity and individuality.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on staff interviews, record review, review of facility documentation and facility policy for 1 of 2 sampled residents (Resident #13) reviewed for mistreatment, the facility failed to prevent a Nurse Aide (NA #3) from working during an investigation of mistreatment. The findings include: Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 2 persons with transfers and toileting. The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings. On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you? On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the investigation summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her. The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me? Interview on 4/4/24 at 3:00 PM with the DNS identified that the incident was brought to her attention on 2/28/24 and that was when she formally initiated the investigation. The DNS indicated that the Administrator was a witness to the incident on 2/22/24 and that the Administrator did not notify her of the event until several days later. The DNS identified that NA #3 was allowed to work at the facility between 2/22/24 and 2/28/24. Interview with NA #3 on 4/9/24 at 11:45 AM identified that she was not directed to stay home from work after the incident and that she worked at the facility on 2/27/24 and 2/28/24. NA #3 indicated that on both 2/27/24 and 2/28/24, she worked on the floor and was assigned to take care of residents but that she was not assigned Resident #13. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the DNS on 4/9/24 at 12:15 PM identified that she was unsure what date the investigation was fully completed for the incident on 2/22/24, but that some of the witness statements for the investigation were obtained on 2/28/24. Additionally, the DNS identified that the facility timecard provided for NA #3 was accurate and that NA #3 had worked in the facility on 2/27/24 and 2/28/24. The DNS identified that she would not have expected that NA #3 would have been allowed to work in the facility after the incident was reported on 2/22/24. Additionally, the DNS indicated that in response to this incident and in her absence, the staffing schedule for NA #3 should have been adjusted by the Administrator. Although attempted, an interview with the Administrator could not be obtained. Review of the facility policy, Abuse/Resident dated 7/23/23, directs abuse or mistreatment of any kind toward a resident as strictly prohibited and that the individual accused will be immediately suspended without pay, pending the findings of the investigation.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 residents (Resident #13 and Resident #40) reviewed for timeliness of providing Activities of Daily Living (ADLs), the facility failed to report an allegation of mistreatment to the State Agency. The findings include: 1. Resident #13's diagnoses include adjustment disorder with mixed anxiety and depressed mood, unspecified dementia and anxiety disorder. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #13 was moderately cognitively impaired and required extensive assistance of 1 with transfers and toileting. The Resident Care Plan (RCP) dated 2/1/24 identified Resident #13 had a problem with determining what was real and what was not, which had proven to hinder some of his/her interactions with peers. Interventions included offering gentle reminders of reality awareness regarding time, place and surroundings. On 4/1/24 at 3:00 PM during the Resident Council meeting, Resident #13 identified that he/she had reported an incident over a month ago regarding Nurse Aide (NA) #3 yelling at him/her and pointing her finger in his/her face. Additionally, Resident #13 indicated that while NA #3 was pointing her finger at him/her, NA #3 was yelling Why are you telling people I won't help you? On 4/1/24, review of the Facility's Investigation Summary form (undated) identified on 2/22/24, between 12:30 PM and 1:30 PM, Resident #13 reported to the Administrator that NA #3 yelled at him/her for asking another NA to toilet him/her. Additionally, the Investigation Summary form identified NA #2 saw NA #3 pointing at Resident #13 and questioning him/her. The Facility Investigation Summary form further identified NA #2 submitted a written statement indicating on 2/22/24 she entered the Dining Room and witnessed NA #3 standing over Resident #13, bending at her waist, pointing in Resident #13's face and yelling Why do you have to lie about me? Interview and record review on 4/1/24 at 3:30 PM with the DNS identified that she was aware of an incident on 2/22/24 with Resident #13 and NA #3. The DNS provided the Facility's Investigation Summary form for the incident on 2/22/24 and indicated that the incident was not reported to the State Agency and did not know the reason the incident was not reported to the State Agency. Interview on 4/4/24 at 3:00 PM with the DNS identified that the incident was brought to her attention on 2/28/24 and that was when she formally initiated the investigation. The DNS indicated that the Administrator was a witness to the incident and that the Administrator did not notify her of the event until several days later. The DNS further identified that she was aware that she or the Administrator should have reported the alleged allegation of mistreatment to the State Agency within two hours of notification. Although attempted, an interview with the Administrator could not be obtained. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent to surveyor inquiry, the DNS reported the incident from 2/22/24 to the State Agency. 2. Resident #40's diagnoses included polyneuropathy, epilepsy, and adjustment disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 was without cognitive impairment and required partial/moderate assistance with personal hygiene, substantial/maximal assistance with bathing, and total dependence with toileting. The Resident Care Plan dated 1/15/24 identified the need for staff assistance with ADLs and that Resident #40 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included to assist as needed to meet toileting needs, incontinent care per policy, that Resident #40 requested not to be woken up during the night but would use the call bell when he/she needed to be changed, and to keep skin clean and dry, applying barrier cream with incontinent care. A Complaint Submission to the Department of Public Health (DPH) Facility Licensing and Investigations Section dated 3/28/24 identified that on 1/28/24, Resident #40 laid in an extremely wet incontinent brief and pad from 2:00 AM until 6:30 AM and on the following day 1/29/24, Resident #40 laid in a feces filled brief from 2:40 PM until 3:20 PM before being changed. He/she voiced concern of developing a urinary tract infection. Interview with the Director of Nursing Services (DNS) on 4/2/24 at 1:00 PM indicated that she was unaware of Resident #40's complaints from 1/28/24 and 1/29/24. The DNS was made aware of these complaints by the Stage Agency surveyor on 4/2/24 at 1:00 PM. Interview with the DNS and [NAME] President (VP) of Clinical Services on 4/3/24 at 1:45 PM identified that no Reportable Event document for these complaints had been completed. The VP of Clinical Services advised that they have the right to gather data before submitting the report to the Stage Agency and that they were still looking into it. Review of the facility's Abuse policy directed, in part, that the Administrator/DNS or designee would immediately conduct an investigation upon submission of a report to the DPH Facility Licensing and Investigations Section within 2 hours of notification of alleged allegation of abuse. 50249

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48879 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 4 sampled residents (Resident #30, Resident #65) reviewed for skin conditions, the facility failed to properly transcribe physician orders resulting in physician orders not being followed (Resident #30) and failed to follow physician's orders regarding Braden Scale Assessments and weekly body audits (Resident #65). Additionally, for the only sampled resident (Resident #71) reviewed for death, the facility failed to ensure that vital signs were taken per the physician orders. The findings include: 1. Resident #30 was admitted to the facility on [DATE] with diagnoses that included cellulitis of left lower limb, Methicillin Resistant Staphylococcus Aureus (MRSA), acute kidney failure, and edema. A Nursing admission note dated 3/7/24 at 8:03 PM and written by RN #4 identified Resident #30 was alert, aware with confusion, had eschar open areas to bilateral lower extremities (BLE), with a treatment of Xeroform and clean dry dressing (CDD). The Nursing admission note and nurses notes failed to identify measurements of the wounds to Resident #30's BLEs. A Resident Care Plan dated 3/7/23 identified Resident #30 had cellulitis, MRSA, chronic venous hypertension, ulcers to bilateral lower extremities, and was at risk for skin breakdown. Interventions included Braden scale completed upon admission and as per facility protocol, watch for increased pain, cramping, aching, and burning of extremities, watch for any signs infection is worsening, watch for fever chills, shaking, sweating, lethargy, dizziness, redness, changes in cognition and odor. Physician orders dated 3/8/24 directed to cleanse Resident #30's bilateral shins with Normal Saline, gently wash with soap and water, and pat dry. Apply Xeroform gauze, cut to wound size, followed by non-adhesive, followed by a dry clean dressing, change every other day and as needed. An admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #30 had intact cognition and required partial/moderate assistance for eating, oral hygiene, and was dependent for toileting. Additionally, the MDS identified Resident #30 was substantial/ maximal assistance for showering, upper body dressing, and dependent for lower body dressing. The MDS further identified Resident #30 had 2 venous/arterial ulcers. A progress note from the Wound Physician (MD #1) dated 3/18/24 directed new wound care orders to cleanse wound, apply Alginate, apply dry clean dressing, and to change daily and as needed for soiling, saturation, and accidental removal. MD #1's progress note further identified measurements of bilateral lower extremities as follows: Right lower extremity (RLE) 1.5 centimeters (cm) by 1.0 cm by 0.1 cm. The left lower extremity (LLE) measured 2 cm by 3.5 cm by 0.1 cm (Resident #30 was admitted on [DATE] with wounds, but wounds had not been measured until 3/18/24). A progress note dated 3/25/24 at 11:14 PM from MD #1 directed treatment recommendations to cleanse with Normal Saline, apply Calcium Alginate to the base of the wound, secure with Super Absorbent Dressing (SAD), and to change daily and as needed for soiling, saturation, or accidental removal (this was a treatment change from 3/18/24). Measurements of the RLE were 1.5 cm by 1.0 cm by 0.1 cm and measurements of the LLE were 3.0 cm by 3.5 cm by 0.1 cm. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A progress note dated 4/1/24 at 5:36 PM from MD #1 directed treatment recommendations to Resident #30's BLE to cleanse with Normal Saline, apply Calcium Alginate to the base of the wound, secure with Super Absorbent Dressing (SAD), and to change daily and as needed. Measurements of RLE were 1.5 cm by 1 cm by 0.1 cm and measurements of the LLE were 4.5 cm by 2.5 cm by 0.1 cm (a larger size than previously measured on 3/25/24). Interview and review of the physician orders and Treatment Administration Record with the DNS on 4/2/24 at 9:10 AM identified that from 3/8/24 through 4/2/24, Resident #30 was receiving a treatment to his/her bilateral shins consisting of Normal Saline, gently wash with soap and water, and pat dry. Apply Xeroform gauze, cut to wound size, followed by non-adhesive, followed by a dry clean dressing despite MD #1's direction to change treatment orders to cleansing with Normal Saline, apply Calcium Alginate to the base of the wounds and securing with SAD on 3/18/24, 3/24/24 and 4/1/24. Additionally, the DNS identified MD #1's wound orders were not transcribed on 3/18/24, 3/25/24 and 4/1/24, resulting in Resident #30 not receiving the appropriate wound treatment, and the clinical record failed to reflect any wound measurements upon admission until measured by MD #1 (10 days after admission). The DNS further identified that MD #1 sends her emails weekly with updated treatment orders but failed to distribute the new treatment orders for Resident #30 to the floor nurses and did not transcribe the new treatment orders. Interview with MD #1 on 4/3/24 at 12:36 PM identified she communicates new orders to the DNS by email and was unaware the current treatment orders did not match her treatment order recommendations. MD #1 further identified she cannot state that Resident #30's LLE wound got worse due to incorrect wound treatment orders being followed as there could be many causes like diet change, not elevating legs and it was hard to say because venous stasis ulcers can be difficult to treat so it was hard to say which factors lead to Resident #30 LLE wound getting worse. Per facility policy on physician orders, all orders are reviewed by the residents physician on next resident visit and covering physicians may give verbal/telephone orders. 2. Resident #65's diagnoses included a right tibia fracture, a history of falls, type 2 diabetes mellitus and chronic kidney disease. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was cognitively intact and required substantial assistance for bed mobility, was dependent for transfers, and required moderate assistance for personal hygiene. Additionally, the MDS identified that Resident #65 was at risk for developing pressure injuries and had Moisture Associated Skin Damage (MASD). The Resident Care Plan (RCP) dated 2/6/24 identified Resident #65 was at risk for skin breakdown due to decreased mobility and incontinence. Interventions included completing the Braden Scale assessment upon admission and per facility protocol. The RCP dated 2/6/24 identified Resident #65 had a right tibia fracture due to a fall. Interventions included following up with the orthopedic physician as recommended, rehab therapy as ordered to increase function and mobility, immobilizer in place as ordered, and the application and removal of the brace as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A physician's order dated 1/11/24 directed that a Braden Scale assessment was to be completed on admission and every week for 4 weeks. Review of the clinical record identified that a Braden Scale assessment was completed on 1/10/24 in the Nursing Admission Assessment, indicating a mild risk of skin breakdown with a score of 16. There were no additional Braden Scale assessments identified in the clinical record. b. A physician's order dated 1/11/24 directed that a body audit was to be completed on admission and every week by a licensed nurse on shower day and was to be documented on the body audit form. Review of the clinical record identified that a body audit assessment was completed on 1/10/24 in the Nursing Admission Assessment, indicating 9 areas of skin abnormalities. There were no additional body audit assessments identified in the clinical record. Interview and clinical record review with RN #3 on 4/1/24 at 11:43 AM identified that there were no additional Braden Scale assessments or body audits completed on Resident #65 after the 1/10/24 Nursing Admission Assessment. She indicated that these assessments should always be completed in the electronic health record under the assessments tab and these assessments were not completed on paper. Additionally, she identified that the 3:00 PM to 11:00 PM nurse was responsible to complete both the Braden Scale and skin assessments. The Braden Scale should have been completed weekly for 4 weeks following admission, and that skin assessments should have been completed for Resident #65 weekly on their shower day. Review of the Braden Scale policy directed, in part, that all residents will have a Braden scale completed weekly for 4 weeks on admission and readmission to the facility, and then it will be completed annually, quarterly and upon a significant change in condition. Review of the Body Audit policy directed, in part, that a licensed nurse will conduct a weekly body audit on the resident, preferably on the shower day, to identify any alterations in skin integrity. The body audit will be signed off by the nurse completing the audit on the Treatment Kardex and the weekly body audit form. 3. Resident #71's diagnoses included cerebrovascular accident (CVA), and dysphagia (difficulty swallowing). The Nursing Admission assessment dated [DATE] identified Resident #71 was cognitively impaired, dependent on staff for eating and required the assistance of 2 staff for bed mobility and transfers. a. An Advanced Practice Registered Nurse's (APRN) order dated 11/29/23 at 3:00 PM directed facility staff to administer the Influenza vaccine and to monitor Resident #71's temperature every shift for 48 hours. A nurse's note dated 11/30/23 at 3:03 PM identified that the Infection Control Nurse (ICN) administered the Influenza vaccine to Resident #71. Review of the clinical record from 11/30/23 through 12/3/23 failed to identify Resident #71's temperatures were taken following the vaccine. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. A nurse supervisor note (written by RN #7) dated 12/6/23 at 11:20 AM identified she had been notified that Resident #71 was hypoxic (low oxygen in body tissues). Further Resident #71 had a normal temperature, elevated heart rate of 110 beats per minute (normal range is 60-80), blood pressure of 122/68 (within normal range), and fine crackles in the bases of the lungs. RN #7 increased Resident #71's oxygen level to 4 liters per minute through a nasal cannula, the APRN was notified, and a new order for an immediate chest x-ray and vital signs every hour for 3 hours was ordered. Review of Resident #71's clinical record on 12/6/23 failed to identify Resident #71's vital signs were monitored every hour for 3 hours on 12/6/23 as directed by the APRN following a change in condition. In an interview with Regional Nurse (RN #5) on 4/3/24 at 1:30 PM, she indicated that the clinical record failed to show that Resident #71's temperatures from 11/30/23 through 12/3/23 and on 12/6/23 that vital signs were monitored as directed by the APRN. Although she was unable to explain the omission, RN #5 indicated that staff should follow APRN orders as directed. 50094 50250

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observation, clinical record review, review of facility policy, and interview for the only sampled resident (Resident #71) reviewed for a death record, the facility failed to ensure that liquids were not accessible to a resident who was on aspiration (choking) precautions. The findings include: Resident #71's diagnoses included cerebrovascular accident (stroke) with left sided paralysis, Barrett's esophagus (narrowed esophagus), and dysphagia (difficulty swallowing). The Nursing Admission assessment dated [DATE] identified Resident #71 was cognitively impaired, dependent on staff for eating, and required the assistance of 2 staff for bed mobility and transfers. The Resident Care Plan (RCP) dated 11/29/23 identified Resident #71 was at risk for aspiration (food or fluids going into the lungs) with interventions that included assisting with feeding, watching for signs/symptoms of aspiration, alternating solids and liquids, encouraging small sips of fluid and small bites of food, encouraging the resident to remain in an upright position, at 90 degrees, for all intake, and to remain upright for 30 minutes to 1 hour after eating. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 was severely cognitively impaired, required maximum assistance with eating, and was dependent for oral hygiene. Additionally, Resident #71 experienced loss of liquids and solids from his/her mouth when eating or drinking, held food in their mouth, coughed or choked during meals, and required a mechanically altered diet of pureed food with thickened liquids. A physician's order dated 12/1/23 directed 1 to 1 supervision for Resident #71 with feeding/eating, and that his/her diet was to be puree textured food, honey thickened liquid consistency, and that Resident #71 required aspiration precautions. A nurse's note (written by RN #6) dated 12/6/23 at 2:39 PM identified Resident #71 had consumed fluid at the bed side and was seen by another staff coughing. Resident #71 was assessed, s/he was afebrile (without fever), his/her oxygen saturation (blood oxygen level) was 68% (normal range is 90% to 100%), and the remainder of the residents vital signs were stable. Oxygen was applied, the Advanced Practice Registered Nurse (APRN) was notified, and a chest x-ray was ordered. Review of Person #2's written report dated 12/7/23 at 11:39 AM identified on 12/6/23 s/he was on a facetime call with Resident #71 and noted that the resident appeared different. Person #2 indicated that while s/he was asking Resident #71's visitor about Resident #71's condition, a male nurse came in and told him/her (Person #2) that a cup of water had been left within Resident #71's reach, the resident had chugged the liquid and aspirated, and was then placed on oxygen. The written report from Person #2 further identified that Resident #71 was recovering from a stroke and required 1 to 1 assistance with feeding prior to this incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. Building B. Wing	04/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Apple Rehab Cromwell	156 Berlin Road Cromwell, CT 06416

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse supervisor note (written by RN #7) dated 12/6/23 at 11:20 AM identified she had been notified that Resident #71 was hypoxic (low oxygen in body tissues). RN #7 indicated Resident #71 had a normal temperature, an elevated heart rate of 110 beats per minute (normal range 60-80), blood pressure of 122/68 (within normal range), and fine crackles in bases of the lungs upon auscultation (listening). RN #7 increased Resident #71's oxygen level to 4 liters per minute through a nasal cannula (tubing). The APRN was notified and directed an immediate chest x-ray and vital signs every hour for 3 hours. A Speech Language Pathologist (SLP) note dated 12/6/23 at 4:57 PM identified that she was asked to see Resident #71 after the resident was found by Physical Therapy (PT) and Occupational Therapy (OT) trying to drink by his/herself which resulted in Resident #71 coughing and having chest congestion. RN #6 was notified immediately. The SLP note further indicated that she encouraged Resident #71 to perform strong coughs, however Resident #71 had difficulty following directions. The SLP attempted to facilitate swallowing with downward lingual pressure (tongue pressure) using an empty spoon, however this was not effective. The SLP subsequently educated staff not to leave food or drink within Resident #71's reach due to his/her required 1 to 1 supervision with food and eating assistance. The SLP noted that Resident #71 was attempting to self-feed, however s/he was not safe to self-feed and that RN #6 then resumed care. An APRN note dated 12/7/23 at 2:51 PM identified Resident #71 was transferred to the hospital with diagnoses of aspiration pneumonia, leukocytosis (elevated white cell count), and acute kidney injury (AKI) due to Resident #71's inability to meet fluid goals, poor oral intake, and an increased oxygen demand. A hospital discharge summary dated 1/9/24 identified Resident #71 was admitted to the hospital's Intermediate Care Unit (IMCU) and required high flow oxygen treatment due acute respiratory failure with hypoxia, aspiration pneumonia of the left lower lobe, and pneumonia due to the COVID-19 virus which had been diagnosed upon arrival to the hospital (12/7/23). Resident #71 had a Percutaneous endoscopic gastrostomy tube (PEG Tube/feeding tube) placed due to severe dysphagia, had a non-ST elevation myocardial infarction (heart attack), and required close telemetry monitoring (heart monitoring). Additionally, it was noted that Resident # 71's hospital stay was complicated by aspiration pneumonia. Interview with RN #6 on 4/9/24 at 12:28 PM, who responded to the incident on 12/6/23, identified that PT notified him that she saw Resident #71 guzzle water from a cup and began to cough. RN #6 ran to Resident #71's room, obtained vital signs, and started Resident #71 on oxygen due to the low oxygen saturation levels. RN #6 was unable to recall the actual oxygen saturation level stating he thought it was 58% or 68%. RN #6 notified both the nursing supervisor and the APRN of the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the SLP on 4/9/24 at 1:26 PM indicated that PT #3 and COTA #1 were walking by Resident #71's room and that from the hallway they observed Resident #71 in bed, alone, in the upright position, with a cup in his/her hand. PT #3/COTA #1 reported that Resident #71 had consumed the fluid, was coughing, and had spilled some liquid on his/her clothing. Additionally, Resident #71 was noted to be congested when breathing and that she was asked to evaluate the resident. The SLP stated that she had tried to get Resident #71 to clear his/her airway by swallowing, but her attempts had been ineffective. The SLP identified that the hospital discharge summary, on Resident #71's arrival to the facility, indicated that Resident #71 required 1 to 1 supervision with meals and that this was continued at the facility on Resident #71's admission orders due to his/her risk for aspiration. Subsequent to assessing Resident #71 after the 12/6/23 incident, the SLP instituted orders for feeding in a few places, not to leave a tray or fluids at the bedside, and to continue the 1 to 1 supervision. Interview with the Occupational Therapy Assistant (COTA #1) on 4/9/24 at 1:57 PM identified that she had helped to reposition and bathe Resident #71 after the resident was noted to have consumed the liquid. COTA #1 noted that the front of Resident #71's [NAME] had been soaked with a thickened liquid. COTA #1 indicated that Resident #71 was not aware that s/he had a deficit following the stroke and lacked initiation and self-awareness. Additionally, COTA #1 identified that she saw liquids and/or food left at bedside, across the room previously and did not believe Resident #71 had the ability to reach over. Interview with PT #3 on 4/9/24 at 2:30 PM identified that on 12/6/23 she had seen Resident #71 from the hallway, in bed, upright, and that the resident was holding a cup in his/her hand. PT #3 noted that Resident #71 was found with fluid down the front of his/her [NAME], and she notified the SLP. PT #3 stated that Resident #71 had a dense stroke, was flaccid on the left side, and had a right sided gaze. PT #3 indicated that Resident #71 was on aspiration precautions, required assistance with eating and drinking and required cues to swallow. Further, PT #3 identified that she had not seen Resident #71 with any visitors in the morning, on the day she discovered him/her holding the cup, only staff were present and upon discovery Resident #71 had been alone in the room with the cup in his/her hand. Interview and observation with Nurse Aide (NA) #4 on 4/9/24 at 3:04 PM identified that she assisted feeding Resident #71 with breakfast on 12/6/23. An observation of Resident #71's previous room identified that the overbed table was on the left side of the bed (as it was currently located) adjacent to the bed with the corner of the overbed table (approximately 6 inches) overlapping the mattress and touching Resident #71's half side rail (as it was currently positioned). Additionally, NA #4 identified that Resident #71 had been sitting upright following breakfast. NA #4 identified she had left Resident #71's thickened drink to the left of Resident #71 thinking that it would be out of his/her reach. NA #4 indicated that Resident #71 did not have visitors in his/her room around the time of and following breakfast, that only staff were present, that dietary staff had passed out the meal and that NA were responsible to distribute fluids. Interview with PT #3, COTA #1 and the SLP on 4/9/24 at 3:17 PM identified that it was unlikely but not impossible for Resident # 71 to reach over to his/her left side while in the upright position and pick up a cup if it had been located on the overbed table (where NA #4 indicated the overbed table had been located and where she had left the resident's beverage). Attempts to reach RN #7 and Person #2 were unsuccessful. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Dysphagia policy identified, in part, that residents with dysphagia have difficulty swallowing liquids and/or solids that might pose a safety issue/risk for aspiration. Aspiration precautions may be instituted on residents who have dysphagia, and who have orders from a physician, nurse, or speech/language pathologist. Further, the Dysphagia policy procedure indicated that aspiration precautions included the head of the bed be elevated to a minimum of 30 degrees, supervision of meals may be identified, and positioning needs may be assessed. Interventions would be resident specific.